# 9 THE MORALITY OF HEALTH CARE PROVISION

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Medical ethics has been defined as "the analytical activity in which the concepts, assumptions, beliefs, attitudes, emotions, reasons and arguments underlying medico-moral decision making are examined critically."[1] This is a hot potato for debate, and anyone hoping that ethics will provide simple straightforward answers will be disappointed.

The goal of medical ethics is to improve the quality of patient care by identifying, analysing, and attempting to resolve the ethical problems that arise in the practice of clinical medicine[2].

The basic preconditions for health are well known, and many societies are willing to consider their equitable distribution. In spite of this, few societies are actively trying to redress inequalities in health. In choosing between policy options that concern such known preconditions for health as education, income, environmental safety, housing, and working conditions, policymakers should consider distributions as well as general average outcomes. But for that to happen, equity in health needs to remain on the political agenda.

Ethics and morality in health care are consequently not the sole domain of medical practitioners.

It is time to admit that we need a two-pronged approach to equity in health: a scientific and a political effort. These may not be synchronised and each has to be allowed to run its own course, but they need to happen simultaneously[3].

On the one hand we are confronted with a teasing scientific problem. Why are social inequalities in health so universal? They show a clear gradient for almost any health indicator by any measure of social position be it education, income, professional class, or social class in every

country where data have been collected, irrespective of the country's position on income distribution, access to education, regulations on working conditions, social benefits, or social housing policies. Why do health inequalities appear to affect almost all diseases, both the diseases of poverty and the lifestyle related diseases of more affluent societies? And, finally, with the limited evidence we have on interventions that seem to improve the health of deprived groups can we confidently recommend policies to governments eager to reduce inequities in health?

It might well be that equity is the most powerful concept to help not only developing countries in their growth towards health for all, but also western countries in trying to adapt health policies for the 21st century. One important opportunity to achieve as much equity in health as possible, given our limited understanding, may be in the daily practice of health care itself. Institutions and individual practitioners need carefully and continuously to ask themselves if their efforts produce equal benefits for those entrusted to their care. Such small-scale efforts are unlikely to resolve the inequalities in health we measure at population level, but a continuing effort at least not to add to these inequalities may well be the best way to preserve equity as a central value in our healthcare services.

The expansion in healthcare delivery over the past 150 years has exacerbated many of the ethical tensions inherent in health care and has created new ones.[4] To answer these problems, many groups of healthcare professionals have established separate codes of ethics for their own disciplines, but no shared code exists that might bring all stakeholders in health care into a more consistent moral framework. A multidisciplinary group last year came together at Tavistock Square in London in an effort to prepare such a shared code. Healthcare delivery everywhere has expanded from what was largely a social service provided by individual practitioners, often in the home, to a complex system of services provided by teams of professionals, usually within institutions and using sophisticated technology. As a result, problems develop, such as the following:

1. The new capabilities and demands of health care dispose providers and members of society to consume resources at an increasing rate.

2. The financial pressures on healthcare delivery have increased, placing the cost of many acute illnesses and chronic care beyond the reach of most individuals.

3. Financing for these services is therefore provided largely through private or public insurance or public assistance. Limited resources require decisions about who will have access to care and the extent of their coverage.

4. The complexity and cost of healthcare delivery systems may set up a tension between what is good for the society as a whole and what is best for an individual patient.

5. Flaws in healthcare delivery systems sometimes translate into bad outcomes or bad experiences for the people served and for the population as a whole. Hence, those working in healthcare delivery may be faced with situations in which it seems that the best course is to manipulate the flawed system for the benefit of a specific patient or segment of the population, rather than to work to improve the delivery of care for all. Such manipulation produces more flaws, and the downward spiral continues.

In recognition of the ethical tensions exacerbated or created by these changes in healthcare systems throughout the world, a draft set of principles was formulated to serve as a guide to ethical decision making in health care. The purpose of this statement of ethical principles is to heighten awareness of the need for principles to guide all who are involved in the delivery of health care. The principles offered here focus healthcare delivery systems on the service of individuals and the good of society as a whole and can offer a foundation for enhanced co-operation among all involved.

Cooperation throughout a healthcare system can produce better outcomes and much greater value for individuals and for society. Such co-operation requires agreement across disciplinary, professional, and organisational lines about the fundamental ethical principles that should guide all decisions in a truly integrated system of healthcare delivery.

Five major principles should govern healthcare systems:

1. Health care is a human right.

2. The care of individuals is at the centre of healthcare delivery but must be viewed and practised within the overall context of continuing work to generate the greatest possible health gains for groups and populations.

3. The responsibilities of the healthcare delivery system include the prevention of illness and the alleviation of disability.

4. Co-operation with each other and those served is imperative for those working within the healthcare delivery system.

5. All individuals and groups involved in health care, whether providing access or services, have the continuing responsibility to help improve its quality.

Clinicians often find themselves in the role of managers being required to set priorities, or they may be affected by the decisions of others about priorities. Priority setting was called "rationing" 20 years ago, and "resource allocation" 10 years ago and is nowadays being called "sustainability", as our language about this problem becomes progressively sanitised.

Sustainability of health services does not merely equate with increased financing. It is a complex matter, which is riddled with hard choices, which have social, political and economic implications, all of which are in turn value laden.

The news that the new tal-Qroqq hospital is estimated to absorb the present health budget *in toto* must come as a shock to our politicians and health planners. While time and time again the value of a well organised system of Primary Care in curtailing ever spiralling costs of health services is mentioned, and although efforts and investment in this field have to date been substantial, they were directed at creating expensive buildings, which are proving increasingly difficult to man and which would operate under the same limitations prevailing at present if and when functional. No more money should be spent to further spread out, extend and clone the existing system, which everyone agrees is not the appropriate one. Rather, major consideration for investment should be given to ongoing training and continued professional development of family physicians. The country urgently requires a comprehensive system of primary health care, gatekeeper style offering continuity of care and expounding the fundamental principles of health education, promotion and prevention, as well as providing therapeutic services including palliative care. The bold decision that must be taken soon, if the much flaunted reforms in primary care are to be effective, is that the private sector must be dovetailed into that provided by the State, not only in open recognition of the invaluable social contribution this sector has made over the years, but more importantly, to provide a real choice to patients in determining who to entrust their health matters to.

The most important recent advance in priority setting has been the development of an ethics framework – accountability for reasonableness – for legitimate and fair decisions on setting priorities.

In October 1998, the BMJ sponsored an international meeting and published a special issue on "Priority setting: the second phase." The first phase had been based on "simple solutions," such as cost effectiveness analysis, on the assumption that it was possible to devise a rational priority setting system that would produce legitimate decisions. The second phase follows the realisation that the idea of devising a simple set of rules is flawed and focuses on the priority setting process itself.

Daniels and Sabin have developed a framework - accountability for reasonableness - for this second phase of priority setting[5]. To make legitimate and fair decisions on priorities, organisations must meet four conditions.

The four conditions of accountability for reasonableness are as follows:

1. *Publicity* – Decisions regarding coverage for new technologies (and other limit setting decisions) and their rationales must be publicly accessible.

2. *Relevance* – These rationales must rest on evidence, reasons, and principles that fair minded parties (managers, clinicians, patients, and consumers in general) can agree are relevant to deciding how to meet the diverse needs of a covered population under necessary resource constraints.

3. *Appeals* – There must be a mechanism for challenge and dispute resolution regarding limit-setting decisions, including the opportunity for revising decisions in the light of further evidence or arguments.

4. *Enforcement* – There must be either voluntary or public regulation of the process to ensure that the first three conditions are fulfilled.

The Maltese NHS has evolved as a compromise between key parties; it allowed those patients who could afford it to have access to both private health care and the NHS, and it permitted consultants to have access to income from private practice while working in the NHS. This safety valve for excess demand was developed contrary to the founding principles of equity, but it has been a feature of health care in Malta allowing more affluent patients to circumvent the periodic funding crises in the NHS while maintaining their support for health care funded by taxes. As a result the share of total healthcare spending contributed by the private sector keeps rising steadily.

It has been argued that the NHS is not sustainable, primarily because funding through taxation will lead to an increasing gap between the demand for and supply of health care. Alternatives to the NHS would involve requiring a larger private contribution to the costs of health care but such systems require complex regulation and seem to produce more inequities than what they propose to resolve. In contrast, expanding the funding of the NHS in line with increases in the gross national product appears to be affordable and broadly equitable.

The NHS continues to have high levels of public support, and close to 70% of the population support the principle of a health service available to all. Above all, Malta compares favourably internationally in terms of fairness of funding, equality of access, and efficiency as evidenced in a recent WHO commissioned study.

It would appear that a higher share of private funding in a mixed economy of public and private care is inevitable and desirable. Critics tend to argue that a publicly funded system, particularly one funded through general taxation, cannot provide the volume and standard of health care that an increasingly affluent, aged, and sophisticated population wants (despite the fact that we cannot determine objectively what level of spending is correct). The main difference between Malta and other comparable countries lies not in the amount of public funding for health care but in the lower level of private funding.

Irrespective of the merits of these arguments there is little doubt that a more mixed economy is emerging in Malta, albeit not always as a direct result of explicit reform of health policy.

Gazing into a crystal ball is rarely rewarding, but it seems that the NHS may move in a way where further changes could occur simply through the accumulation of seemingly separate smaller scale changes which would further reduce the contribution of publicly funded health services, as has happened so far.

On the other hand politicians have never been more aware than today that this is a risky path to follow as lack of foresight and planning could well send the whole system into chaos. Some indications as to the trend that the NHS may follow in future can be gleaned from the occasional ministerial slip or statement. Other possible directions may be deduced from what other countries, sharing the same funding problems have considered as possible options.

It would not be unreasonable to predict that the country may be faced with the following developments that may alter the mix of financing for health care:

- Removal of the tax payable on private insurance schemes in the short term – a yet unfulfilled electoral promise,
- Plans for compulsory private medical insurance in the long term,
- Changes in social security leading to a requirement for personal insurance against accident, sickness and retirement,
- Commercial funding for all major NHS capital schemes,
- Moving NHS dental care into the private sector,
- Government plans to charge insurers for the full cost of NHS treatment of motorists and passengers involved in road accidents.

The survival of health services lies largely in the hands of Government. Various governments have introduced different reforms aimed at making the system sustainable in the face of present and future challenges. Arguments about the adequacy of funding are likely to continue because it is a matter of value judgement, which of necessity is made by Government. However, Government also has the ability to modify the pressures on the health services and so how well it copes is, at least partly, a function of political choice. Government could try to reduce demands arising from increased expectations by encouraging informed

public debate about priorities and influencing the availability of private health care.

If Government wishes to sustain its health services then it needs to engage the public in deciding how to trade these values and brace itself for an ever-increasing financial allocation to this sector, with major internal re-distribution of funds where spending has been shown scientifically to contain overall health costs.

Maybe the most important development will be in our sensibilities. Having been told for so long that change is inevitable, the prospect of change does not seem quite so alarming, even though the evidence that it will solve the énduring problems of health care in Malta is lacking.

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